

Basic Medicaid



Mental Health

Video Conference Disclaimer



- ***This video conference is being presented on November 6, 2006 by Chris Ferrell, an employee of EDS, the Fiscal Agent for the North Carolina Medicaid Program. All information provided during this video conference is believed to be accurate and reliable; however, the Division of Medical Assistance (DMA) assumes no responsibility for the use of this information. In the event of discrepancies between the oral presentation, and the published information (general and special Medicaid bulletins), the published information shall be the final authority. Information presented during this video conference is also provided in the Basic Medicaid Billing Guide October 2006. This video conference is based on these written guidelines. The information presented in this video conference is subject to change. Providers are typically notified of changes and updates through subsequent general and/or special bulletins.***

New Web Address



www.ncdhhs.gov/dma

Old address:

www.dhhs.state.nc.us/dma



Division of Medical Assistance

Providing access to high quality, medically necessary health care for eligible North Carolina residents through cost effective purchasing of health care services and products.

Provider Links

Consumer Links

County Links

Programs

Publications



The Division of Medical Assistance (DMA) oversees two programs: Medicaid and [NC Health Choice for Children](#).

North Carolina's Medicaid program serves approximately one out of every eight people residing in our state. Last year, Medicaid served approximately 1.5 million children, aged, blind and/or disabled individuals. This year's budget for the Medicaid is \$10,262,267,093 – of which is supported by \$7.6B in revenue (predominately federal Medicaid funds) and just under \$2.6B in state appropriations. Medicaid's budget is one of the largest in NC government – second only to overall budget for primary and secondary education.

[NC Health Choice for Children \(NCHC\)](#) provides funding to extend health care coverage to roughly 115,000 children each month whose family income exceed Medicaid eligibility criteria. The budget for NCHC is \$196,868,437 – of which \$145M is supported by federal funds and \$52M in state appropriations. DMA partners with the State Employee's Health Plan and NC Blue Cross/Blue Shield in administering this program.



News and Hot Topics

- [N.C. Medicaid Ends Year \\$350 Million Under Budget](#)
- [2005 Medicaid Annual Report](#)
- [National Provider Identifier \(NPI\) Information](#)
- [Mental Health Reform](#)
- [We have a new web address! \[www.ncdhhs.gov/dma\]\(http://www.ncdhhs.gov/dma\)](#)



Guía del Usuario para Medicaid en Carolina del Norte (En Español)

Contact Us

Who We Are - DMA Organization

Disclaimer

[Medicaid "Be Smart" Family Planning Program](#)
[The Official U.S. Government Site for People with Medicare](#)
[DHHS Customer Service Home Page](#)
[Quality Initiatives](#)
[North Carolina Institutional Bias Study Combined Report](#)
[Solicitations by Purchasing Entity - Health and Human Services](#)



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National Provider Identifier (NPI) Information

Get It! Share It! Use It! Now! Getting one is free - Not having one can be costly!

- DMA NPI Collection Form
 - Group Form
 - [PDF Format](#)
 - Individual Form
 - [PDF Format](#)
- Seminar Information and Upcoming Trainings
 - [Stakeholder's Meeting Presentation - September 7, 2006](#)
 - [Seminar Schedule \(October 2006\) - New Raleigh Date!](#)
 - [October 2006 Seminar Presentation](#)
- DMA Bulletin Articles
 - [June 2006](#)
 - [August 2006](#)
 - [September 2006](#)
- [CMS Tip Sheet](#)
- [CMS Fact Sheets](#)
- Other Related Sites
 - [DHHS NPI Home Page](#)
 - [How to apply for your NPI](#)
 - [CMS Home Page](#)
 - [State Medicaid Director Letter](#)
 - [Taxonomy Code Set](#)



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Mental Health Information

New Bulletins to Web

- [Authorization and Utilization Review for Behavioral Health Services - July 2006](#)
- [Utilization Review of CAP/MR/DD Services and Targeted Case Management - July 2006](#)

Helpful Links

- [Application for Community Intervention Services](#)
- [Approvals of Local Management Entities \(LMEs\) to Directly Provide Services](#)
- [Clinical Coverage Policies](#)
- [Cost Report \(unavailable\)](#)
- [Division of Mental Health, Developmental Disabilities, and Substance Abuse Services Communications Documents](#)
- [FAQ's \(unavailable\)](#)
- [IPRS Webpage](#)
- [Mental Health Fee Schedules](#)

Training Documents

- [Basic Medicaid Billing Guide](#)
- [Enhanced Benefit Mental/Substance Abuse Services, Phase I, September 2005](#)
- [Enhanced Benefit Mental Health/Substance Abuse Services, Phase II, January 2006](#)
- [Expansion of Provider Types for Outpatient Behavioral Health Services, Phase II Special Bulletin IV, May 2005](#)
- [Targeted Case Management for Mentally Retarded/Developmentally Disabled \(MR/DD\) Individuals, Special Bulletin VI, July 2005](#)

Last updated June 30, 2006



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Information for Medicaid Providers

[Bulletins](#) | [Contact Lists](#) | [Cost Reports](#) | [Forms](#) | [HIPAA](#)
[Frequently Asked Questions](#) | [NPI Information](#) | [Pharmacy](#) | [Provider Enrollment Packages](#) | [Publications](#)

New to Web!



- [National Provider Identifier \(NPI\) Information](#)
- [October 2006 General Medicaid Bulletin](#)
- [Basic Medicaid Billing Guide, October 2006](#)

Registration and Seminar Information



- [Basic Medicaid Billing Seminar Schedule - October 2006](#)
- [Community Support, Diagnostic Assessment & Services within Developmental Disabilities Video Conference - September 2006](#)
- [National Provider Identifier \(NPI\) Informational Seminar Schedule \(October 2006\) - New Raleigh Date!](#)

Provider Information



- [Basic Medicaid Billing Guide](#)
- [BLUE E Information](#)
- [Carolina ACCESS Primary Care Provider Forms](#)
- [Clinical Coverage Policies and Provider Manuals](#)
- [Health Check and EPSDT](#)
- [Health Check Billing Guide](#)
- [Hurricane Katrina Information](#)
- [Medicaid Family Planning Waiver Information for Providers](#)
- [New NCLeads \(Medicaid Management Information System-MMIS\)](#)
- [Proposed Clinical Coverage Policies](#)
- [Provider Enrollment Packages](#)
- [Provider Forms](#)

Forms



- [Carolina ACCESS Primary Care Provider Forms](#)
 - [County Forms](#)
 - Hospital ACH DATA for Medicaid Reimbursement Initiative (MRI) Interim Payments **ONLY**
 - [Hospital ACH Data Set Up/Change Form Instructions](#)
 - [Hospital ACH Data Set Up/Change Form](#) (NOT FOR EDS)
 - [Outpatient Pharmacy Services Forms](#)
 - [Provider Forms](#)
 - [Third Party Recovery Forms](#)
-

Publications



- [Checkwrite Schedule](#)
 - [Fee Schedules](#)
 - [Holiday Observance Schedule for 2006](#)
 - [Mecklenburg County MCO Risk Contract](#) (456 KB [Adobe Acrobat Reader](#))
 - [Mental Health Fee Schedules](#)
 - [Medicaid General and Special Bulletins](#)
 - [Medicaid Services Information \(Clinical Coverage Policies, Provider Manuals, and Seminar Handouts\)](#)
 - [Pharmacy Newsletters](#)
 - [PACE Development in N.C.](#)
 - [Quality, Evaluation, and Health Outcomes Unit Initiatives](#)
 - [Third Party Recovery - Forms and Insurance Codes](#)
-

Contact Lists



- [Automated Attendant Telephone Line Instructions](#)
 - [Automated Voice Response \(AVR\) System Instructions](#)
 - [CAP/DA Lead Agency List](#) (49 KB [Adobe Acrobat Reader](#))
 - [DMA and Electronic Data Systems \(EDS\) Telephone Contacts and Addresses](#)
 - [EDS Provider Services Representatives](#)
 - [Health Check Coordinators](#) (149 KB [Adobe Acrobat Reader](#))
 - [If you suspect fraud](#)
 - Mental Health Provider List - October 2006
 - [Adobe Acrobat Format](#)
 - [Microsoft Excel Format](#)
 - [Prior Authorization for High Cost Drugs](#)
 - [Regional Managed Care Regional Consultants](#) (10 KB [Adobe Acrobat Reader](#))
-

Frequently Asked Questions

- [Carolina ACCESS Primary Care Providers](#)
 - [North Carolina Health Choice Providers](#)
-

Health Insurance Portability and Accountability Act (HIPAA)



- [Companion Guides](#)
Technical guides for use by the provider community, Managed Care Organizations (MCO's), and billing agents.
 - [DMA HIPAA Implementation Announcements](#)
 - [DMA HIPAA Information](#)
 - [DMA HIPAA Information from the North Carolina Medicaid Bulletins](#)
 - EOB Crosswalk to National Codes
 - [Adobe Acrobat Format](#)
 - [Microsoft Excel Format](#)
 - [HIPAA Frequently Asked Questions](#)
 - [HIPAA Information from the Centers for Medicare and Medicaid Services](#)
 - [NCECS-Web Tool Implementation Announcements](#)
 - [Trading Partner Agreement](#) (27 KB [Adobe Acrobat Reader](#))
-

Cost Reports

- [ACH-PCS Cost Settlements](#)
- [Community Alternatives Program - Mentally Retarded \(CAP-MR\) Cost Report](#)
- [Family Care Home Cost Report](#)
- [Federally Qualified Health Center/Rural Health Clinic \(FQHC/RHC\) Cost Report](#)
- [Home Office Cost Statement](#)
- [Hospital-Based Nursing Facility Cost Report](#)
- [Hospital Cost Report Instructions/NCDMA E-5/Certification](#) (54KB - Microsoft Excel)
- [Intermediate Care Facility/Mentally Retarded \(ICF/MR\) Cost Report](#)
- [Nursing Facility Cost Report](#)
- [Personal Care Services \(PCS\) Cost Report](#)
- [Rate Adjustment Eligibility Worksheet](#) (55 KB - Microsoft Excel)
- [Schedules A, B and C for Hospitals](#) (132 KB - Microsoft Excel)
- [Intermediate Care Facility/Mentally Retarded \(ICF/MR\) Assessment](#)
- [Nursing Facility Assessment](#)

Updated October 26, 2006

Recipient Eligibility



Build-A-Card

THIS DOCUMENT CONTAINS FLUORESCENT FIBERS, FLUORESCENT ARTIFICIAL WATERMARK AND IS PRINTED ON CHEMICAL REACTIVE PAPER

MEDICAID IDENTIFICATION CARD

10-01-06 to 10-31-06

P.O. Box 111
Any City, NC
Zip=12345

CASE ID 10847667
CASEHEAD Jane Recipient

Eligible Members

Jane Recipient

123-45-6789K

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

CAP	COUNTY CASE NO	ISSUANCE	H		A		
	123456	06272 S					
G		B			INS NO	BIRTHDATE	SEX
					1	12-17-73	F
		E					
C				F			
				D			

MISUSE MAY RESULT IN FRAUD PROSECUTION

(Signature)

Jane Recipient

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VALID

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C			F		
			D		

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			D					

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VALID

CAP	COUNTY CASE NO 123456	ISSUANCE 06272 S	H	FROM 10-01-06	THRU 10-31-06	
RECIPIENT ID 123-45-6789K	ELIGIBLES FOR MEDICAID Jane Recipient			INS NO 1	BIRTHDATE 12-17-73	SEX F
E			F			
C			D			

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VALID

CAP	COUNTY CASE NO	ISSUANCE	PROGRAM	CLASS	FROM	THRU					
	123456	06272 S	AAF	N	10-01-06	10-31-06					
RECIPIENT ID	ELIGIBLES FOR MEDICAID				INS NO	BIRTHDATE	SEX				
123-45-6789K	Jane Recipient				1	12-17-73	F				
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RECIPIENT ID	ELIGIBLES FOR MEDICAID				INS NO	BIRTHDATE	SEX		
123-45-6789K	Jane Recipient				1	12-17-73	F		
555-555-5555		555-555-5555							
C				F					
				D					

**Carolina ACCESS Provider
Address and Phone number**

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RECIPIENT ID	ELIGIBLES FOR MEDICAID				INS NO	BIRTHDATE	SEX
123-45-6789K	Jane Recipient				1	12-17-73	F
	Dr Joe PCP Provider						
	123 Any Street						
	Any City, NC 12345						
	555-555-5555				555-555-5555		

C

Carolina ACCESS Enrollee

D

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Eligible Members

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123-45-6789K	Jane Recipient				1	12-17-73	F
	Dr Joe PCP Provider						
	123 Any Street						
	Any City, NC 12345						
	555-555-5555				555- 555-5555		

C

Carolina ACCESS Enrollee

Oct 2006

10847667 101

That City, NC 45678

RECIPIENT (Not valid unless signed)
(Signature) *Jane Recipient*

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RECIPIENT ID		ELIGIBLES FOR MEDICAID			INS NO	BIRTHDATE	SEX
123-45-6789K		Jane Recipient Dr Joe PCP Provider 123 Any Street Any City, NC 12345 555-555-5555			1	12-17-73	F
INS NO	NAME CODE	POLICY NUMBER		TYPE	Carolina ACCESS Enrollee		
		1 Medicare-B			OCT 2006 AAF11 10847667 101 456 That Street That City, NC 45678		
RECIPIENT					(Not valid unless signed)		
(Signature)							

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Zip=12345

CASE ID 10847667
CASEHEAD Jane Recipient

Eligible Members

Jane Recipient

123-45-6789K

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RECIPIENT ID	ELIGIBLES FOR MEDICAID				INS NO	BIRTHDATE	SEX
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					(Signature) <i>Jane Recipient</i>		

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ISSUANCE	PROGRAM	CLASS
060323	AAF	N

FROM 10-01-06 THRU 10-31-06

ELIGIBLES FOR MEDICAID		INS NO	BIRTHDATE	SEX
		1	12-17-73	F

CASE #

CASE #

Recipient
PCP Provider
Any Street
Any City, NC 12345

Eligible

555-555-5555

555-555-5555

Jane Recip

123-45-6789

NAME CODE	POLICY NUMBER	TYPE
091	Y23684219	00

Carolina ACCESS Enrollee
OCT 2006 AAF11 10847667 101
456 That Street
That City, NC 45678

RECIPIENT (Not valid unless signed)
(Signature) *Jane Recipient*

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Family Planning Waiver

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P.O. Box 111
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Zip=12345

CASE ID 10847667
CASEHEAD Jane Recipient

Eligible Members

Jane Recipient

123-45-6789K

Family
Planning
Limited

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

VALID

CAP	COUNTY CASE NO 123456	ISSUANCE 06272 S	PROGRAM MAF	CLASS D	FROM 10-01-06	THRU 10-31-06
RECIPIENT ID 123-45-6789K		ELIGIBLES FOR MEDICAID Jane Recipient *** Family Planning Waiver *** Recipient Eligible For Limited Family Planning Services Only			INS NO	BIRTHDATE 08-02-1971
INS NO	NAME CODE	POLICY NUMBER		TYPE	OCT 2006 MAF34 10847667 101 456 That Street That City, NC 45678	
					RECIPIENT (Not valid unless signed) (Signature) <i>Jane Recipient</i>	

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Family Planning Waiver

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INS NO	NAME CODE	POLICY NUMBER		TYPE	OCT 2006 MAF34 10847667 101 456 That Street That City, NC 45678	
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CASEHEAD Jane Recipient

Eligible Members

Jane Recipient

123-45-6789K

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VALID

CAP	COUNTY CASE NO 123456	ISSUANCE 06272 S	PROGRAM MAF	CLASS D	FROM 10-01-06	THRU 10-31-06
RECIPIENT ID 123-45-6789K		ELIGIBLES FOR MEDICAID Jane Recipient			INS NO	BIRTHDATE 08-02-1971
					SEX F	
INS NO	N. CODE			OCT 2006 MAF34 10847667 101 456 That Street That City, NC 45678		
				RECIPIENT (Not valid unless signed) (Signature) <i>Jane Recipient</i>		

***** Family Planning Waiver *****
Recipient Eligible For Limited
Family Planning Services Only

MISUSE MAY RESULT IN FRAUD PROSECUTION

Piedmont Cardinal Health Plan, PCHP



- ❑ March 2005 Special bulletin
- ❑ Mandatory Program
- ❑ Cabarrus, Rowan, Stanly, Union, or Davidson counties
- ❑ Caseworkers will inform recipients
- ❑ Providers will contract with PCHP for reimbursement

Piedmont Cardinal Health Plan

THIS DOCUMENT CONTAINS FLUORESCENT FIBERS, FLUORESCENT ARTIFICIAL WATERMARK AND IS PRINTED ON CHEMICAL REACTIVE PAPER

MEDICAID IDENTIFICATION CARD

* = PCHP

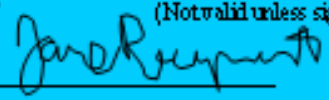
VALID

10-01-06 to 10-31-06

P.O. Box 111
Any City, NC
Zip=12345

CASE ID 10847667
CASEHEAD Jane Recipient

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

CAP	COUNTY CASE NO 123456	ISSUANCE 06272 S	PROGRAM AAF	CLASS N	FROM 10-01-06	THRU 10-31-06
RECIPIENT ID 123-45-6789K		ELIGIBLES FOR MEDICAID * Jane Recipient			INS NO 1	BIRTHDATE 12-17-73
INS NO 1	NAME CODE 091	POLICY NUMBER Y23684219		TYPE 00	OCT 2006 AAF11 10847667 101 456 That Street That City, NC 45678	
					RECIPIENT (Not valid unless signed) (Signature) 	

Eligible Members

Jane Recipient

123-45-6789K

MISUSE MAY RESULT IN FRAUD PROSECUTION

Basic Med 2-8

Piedmont Cardinal Health Plan

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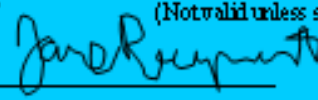
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Basic Med 2-8

Medicaid for Pregnant Women

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RECIPIENT ID 123-45-6789K		ELIGIBLES FOR MEDICAID Jane Recipient			INS NO 1	BIRTHDATE 12-17-73
INS NO 1	NAME CODE 091	POLICY NUMBER Y23684219		TYPE 00	OCT 2006 MPWN11 10847667 101 456 That Street That City, NC 45678	
This recipient is only entitled to receive pregnancy related services which include prenatal, delivery and postpartum care as well as services required for conditions which may					RECIPIENT (Not valid unless signed) (Signature) <i>Jane Recipient</i>	

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N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

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CAP	COUNTY CASE NO	ISSUANCE	PROGRAM	CLASS
	123456	06272 S	MPW	N

FROM 10-01-06 THRU 10-31-06

RECIPIENT ID	ELIGIBLES FOR MEDICAID	INS NO	BIRTHDATE	SEX
123-45-6789K	Jane Recipient	1	12-17-73	F

INS NO	NAME CODE	POLICY NUMBER	TYPE
1	091	Y23684219	00
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OCT 2006 MPWN11 10847667 101
456 That Street
That City, NC 45678

RECIPIENT (Not valid unless signed)
(Signature) *Jane Recipient*

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N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

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CAP	COUNTY CASE NO	ISSUANCE	PROGRAM	CLASS	FROM	THRU
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Medicare-Aid ID

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CUT ALONG DOTTED LINES

NOTICE TO RECIPIENT

USE OF CARD – This card is proof of eligibility for MEDICARE-AID for the month(s) shown in the Valid From and Thru Dates. You will receive a card each month you are eligible. It is to be used with your MEDICARE card so that your medical providers can bill the MEDICAID program for MEDICARE cost sharing. Lost cards may be replaced at the county DSS. Always notify your caseworker of any change in your income, resources or living situation. This card is valid only for medical care and services covered by both Medicare and Medicaid.

RIGHT TO RECONSIDERATION REVIEW – You have the right to request a review if a provider bills you cost sharing amounts that you expected to be paid by the Medicaid program. To ask for a review, write to: DMA, 2519 Mail Service Center, Raleigh, N.C. 27699-2519 within 60 days of receiving the bill.

FRAUD – Use of this card by anyone not listed on the card is fraud and is punishable by a fine, imprisonment or both.

DO YOU HAVE QUESTIONS? – If you have questions about using your ID Card or your Medicaid eligibility, please contact your county department of social services.

MEDICARE-AID ID CARD

N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

VALID

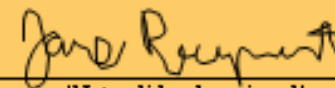
FROM 10-01-06 THRU 10-31-06

PROGRAM	ISSUANCE			
MQB	06272			
RECIPIENT ID.		INS. NAME CODE	BIRTHDATE	SEX
123-456-789K		091	08-28-1929	F

OCT 2006 MQB 61 76543210 004

Jane Recipient
123 Any Street
Any City, NC 12345

(Signature)



(Not valid unless signed)

Medicare-Aid ID

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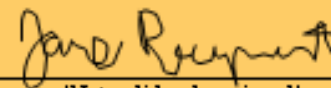
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RECIPIENT ID. 123-456-789K		INS. NAME CODE 091	BIRTH DATE 08-28-1929	SEX F

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N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE

VALID

PROGRAM	ISSUANCE
MQB	06272

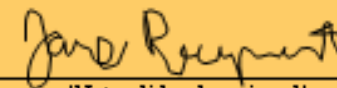
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RECIPIENT ID.	INS. NAME CODE	BIRTH DATE	SEX
123-456-789K	091	08-28-1929	F

OCT 2006 MQB 61 76543210 004

Jane Recipient
123 Any Street
Any City, NC 12345

(Signature)



(Not valid unless signed)

MQBB and MQBE Recipients



- ❑ Special Low Income Medicare Beneficiaries
- ❑ Do not receive a Medicaid ID card
- ❑ Medicaid pays for their part B premiums
- ❑ Do not bill Medicaid for their services

Managed Care



□ Remember:

- DSS enrolls recipient into Managed Care program
- Providers must indicate Carolina ACCESS PCP's authorization on claim
- Verify recipient's PCP through the AVRS, MID card or 270/271 HIPAA transactions
- Carolina ACCESS overrides can not override program requirements.

Attention: Direct Enrolled Mental Health Providers and Local Management Entities

Carolina ACCESS Override Requests

Mental health services provided to recipients under the age of 21 require a referral from the recipient's Carolina ACCESS primary care provider (PCP), the LME or a Medicaid enrolled psychiatrist. Obtaining a Carolina ACCESS override does not override the referral requirements referenced in the January 2005 and May 2005 Medicaid special bulletins. The special bulletins are available on DMA's website at <http://www.dhhs.state.nc.us/dma/bulletin.htm>.

Please contact EDS Provider Services for billing questions.

EDS, 1-800-688-6696 or 919-851-8888

<http://www.dhhs.state.nc.us/dma/bulletin/0406bulletin.pdf>

Time Limit



- ❑ 365 days from the first date of service on the claim (except inpatient and nursing facilities)
- ❑ 180 days from the date of the Third Party or Medicare EOB
- ❑ 18 months from date of EOB from Medicaid to follow up on timely claims

Submitting Claims on Paper



- ❑ Use black ink only – do not highlight the claim
- ❑ Claim must be signed by the provider unless provider has filled out a Certification for Signature on File form

PLEASE
DO NOT
STAPLE
IN THIS
AREA

Billing Medicaid – CMS-1500

HEALTH INSURANCE CLAIM FORM						PICA
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>						1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
<input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (SSN) <input type="checkbox"/> (ID)						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
CITY		STATE		CITY		STATE
ZIP CODE		TELEPHONE (Include Area Code) ()		ZIP CODE		TELEPHONE (INCLUDE AREA CODE) ()
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. ID NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		

CARRIER

PATIENT AND INSURED INFORMATION

Billing Medicaid – New CMS-1500

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 58/05

TIPICA				PICA			
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN)</small>				1a. INSURED'S ID NUMBER <small>(For Program in Item 1)</small>			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No. Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No. Street)	
CITY		STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY	
ZIP CODE		TELEPHONE (Include Area Code) ()		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		b. INSURED'S DATE OF BIRTH MM DD YY			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. EMPLOYER'S NAME OR SCHOOL NAME			
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		d. INSURANCE PLAN NAME OR PROGRAM NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME		10a. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 and</i>			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____			
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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. DR <input type="checkbox"/> 17b. NPI <input type="checkbox"/>		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by line)				22. MEDICAID RESUBMISSION CODE ORIGINAL REF NO			

PATIENT AND INSURED INFORMATION

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25. FEDERAL TAX ID NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>			26. PATIENT'S ACCOUNT NO.																																																																																																
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$ _____ 29. AMOUNT PAID \$ _____ 30. BALANCE DUE \$ _____																																																																																																
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Identify that the statements on the reverse apply to this bill and are made a part thereof) SIGNED _____ DATE _____			32. SERVICE FACILITY LOCATION INFORMATION a. _____ b. _____																																																																																																
33. BILLING PROVIDER INFO & PH # () a. _____ b. _____																																																																																																			

PHYSICIAN OR SUPPLIER INFORMATION

Billing Medicaid – UB-92

APPROVED OMB NO. 0938-0279

		2		3 PATIENT CONTROL NO.				4 TYPE OF BILL																							
		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH		7 COV D.	8 N-C.D.	9 C-I.D.	10 L-R.D.	11																					
12 PATIENT NAME				13 PATIENT ADDRESS																											
14 BIRTHDATE		15 SEX	16 MS	17 DATE		18 HR		19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.		24		25		26		27		28		29		30		31			
32 OCCURRENCE DATE		33 CODE		34 OCCURRENCE DATE		35 CODE		36 OCCURRENCE DATE		37 CODE		38 OCCURRENCE DATE		39 CODE		40 OCCURRENCE DATE		41 CODE		42 OCCURRENCE DATE		43 CODE		44 OCCURRENCE DATE		45 CODE		46 OCCURRENCE DATE		47 CODE	
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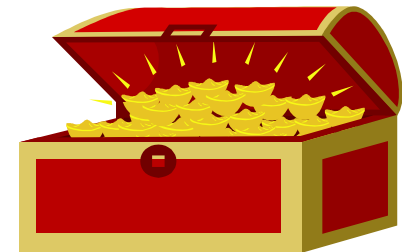
Billing Medicaid – UB-04

[illegible]

PAGE ____ OF ____										CREATION DATE										TOTALS																													
50 PAYER NAME										51 HEALTH PLAN ID										52 PRIOR PAYMENTS										53 EST. AMOUNT DUE										54 NPI									
																																								55 OTHER PHY ID									
56 INSURED'S NAME										57 PRIOR										58 INSURED'S UNIQUE ID										59 GROUP NAME										60 INSURANCE GROUP NO									
61 TREATMENT AUTHORIZATION CODES										62 DOCUMENT CONTROL NUMBER										63 EMPLOYER NAME																													
64 DX																																																	
65 ADMIT DX										66 PATIENT REASON DX										67 ICD-9 CODE										68 ICD-10 CODE																			
74 PRINCIPAL PROCEDURE CODE DATE										75 OTHER PROCEDURE CODE DATE										76 OTHER PROCEDURE CODE DATE										77 ATTENDING NPI QUAL																			
																														78 LAST FIRST																			
79 OTHER PROCEDURE CODE DATE										80 OTHER PROCEDURE CODE DATE										81 OTHER PROCEDURE CODE DATE										77 OPERATING NPI QUAL																			
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										85 ICD-9 c										86 ICD-10 d										79 OTHER NPI QUAL																			
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What is a Remittance and Status Report (RA)?

- ❑ Computer-generated document showing the status of all claims submitted to EDS
- ❑ Shows detailed breakdown of payments



Sample RA



Medical Center
123 Medicine Lane
Medical Park, NC 12345

89XXXXX

10/1/2006

PAID CLAIMS MEDICAL

RECIPIENT JANE CO=01 RCC= CLAIM NUMBER= 102006023600000NCXIX
123456789K PAT ACCT=12345 MED REC=12345
NCXIX 09012006 09012006 1.000 99212 OV ESTABLISHED PT, MINOR-PH
DED= .00 PT LIB= .00 CO PAY= .00 TPL= .00 DIFF= .00
ORIGINAL BILLED AMOUNT= 92.00 ORIGNAL DETAIL COUNT=

EST AMT DUE=
ATTN PROV=79XXXXX 1.0000
9200 5712 3488 0 3488 0 3488 98
9200 5712 3488 0 3488 0 3488
TOTAL FINANCIAL PAYERS= 1

DENIED CLAIMS MEDICAL

RECIPIENT JOE CO=01 RCC= CLAIM NUMBER= 102006024600000NCXIX
987654321K PAT ACCT=54321 MED REC=54321
NCXIX 09012006 09012006 1.000 99212 OV ESTABLISHED PT, MINOR-PH
KA
DED= .00 PT LIB= .00 CO PAY= .00 TPL= .00 DIFF= .00
ORIGINAL BILLED AMOUNT= 92.00 ORIGNAL DETAIL COUNT=

EST AMT DUE=
ATTN PROV=79XXXXX 1.0000
9200 5712 3488 0 3488 0 0 24
9200 5712 3488 0 3488 0 0
TOTAL FINANCIAL PAYERS= 1

Sample RA



Medical Center
123 Medicine Lane
Medical Park, NC 12345

89XXXXX

10/1/2006

PAID CLAIMS

RECIPIENT JANE CO=01 RCC= CLAIM NUMBER= 102006023600000NCXIX
123456789K PAT ACCT=12345 MED REC=12345
NCXIX 09012006 09012006 1.000 99212 OV ESTABLISHED PT, MINOR-PH
DED= .00 PT LIB= .00 CO PAY= .00 TPL= .00 DIFF= .00
ORIGINAL BILLED AMOUNT= 92.00 ORIGINAL DETAIL COUNT=

EST AMT DUE=
ATTN PROV=79XXXXX 1.0000
9200 5712 3488 0 3488 0 3488 98
9200 5712 3488 0 3488 0 3488
TOTAL FINANCIAL PAYERS= 1

DENIED CLAIMS

RECIPIENT JOE CO=01 RCC= CLAIM NUMBER= 102006024600000NCXIX
987654321K PAT ACCT=54321 MED REC=54321
NCXIX 09012006 09012006 1.000 99212 OV ESTABLISHED PT, MINOR-PH
KA
DED= .00 PT LIB= .00 CO PAY= .00 TPL= .00 DIFF= .00
ORIGINAL BILLED AMOUNT= 92.00 ORIGINAL DETAIL COUNT=

EST AMT DUE=
ATTN PROV=79XXXXX 1.0000
9200 5712 3488 0 3488 0 0 24
9200 5712 3488 0 3488 0 0
TOTAL FINANCIAL PAYERS= 1

Sample RA



Medical Center
123 Medicine Lane
Medical Park, NC 12345

89XXXXX

10/1/2006

PAID CLAIMS

ICN

RECIPIENT	JANE	CO=01	RCC=	CLAIM NUMBER= 102006023600000NCXIX	EST AMT DUE=						
	123456789K	PAT ACCT=12345		MED REC=12345	ATTN PROV=79XXXXX	1.0000					
NCXIX	09012006 09012006	1.000		99212 OV ESTABLISHED PT, MINOR-PH	9200 5712 3488 0 3488		0	3488	98		
DED=	.00	PT LIB=	.00	CO PAY=	.00	TPL=	.00	DIFF=	.00		
ORIGINAL BILLED AMOUNT=				92.00	ORIGINAL DETAIL COUNT=						
					9200 5712 3488 0 3488		0	3488			
					TOTAL FINANCIAL PAYERS=	1					

DENIED CLAIMS

RECIPIENT	JOE	CO=01	RCC=	CLAIM NUMBER= 102006024600000NCXIX	EST AMT DUE=						
	987654321K	PAT ACCT=54321		MED REC=54321	ATTN PROV=79XXXXX	1.0000					
NCXIX	09012006 09012006	1.000		99212 OV ESTABLISHED PT, MINOR-PH KA	9200 5712 3488 0 3488		0	0	24		
DED=	.00	PT LIB=	.00	CO PAY=	.00	TPL=	.00	DIFF=	.00		
ORIGINAL BILLED AMOUNT=				92.00	ORIGINAL DETAIL COUNT=						
					9200 5712 3488 0 3488		0	0			
					TOTAL FINANCIAL PAYERS=	1					

Sample RA



Medical Center
123 Medicine Lane
Medical Park, NC 12345

89XXXXX

10/1/2006

PAID CLAIMS

RECIPIENT	JANE	CO=01	RCC=	CLAIM NUMBER= 102006023600000NCXIX	EST AMT DUE=					
	123456789K	PAT ACCT=12345		MED REC=12345	ATTN PROV=79XXXXX	1.0000				
NCXIX	09012006 09012006	1.000		99212 OV ESTABLISHED PT, MINOR-PH	9200 5712 3488 0 3488	0 3488	98			
DED=	.00	PT LIB=	.00	CO PAY=	.00	TPL=	.00	DIFF=	.00	
ORIGINAL BILLED AMOUNT=	92.00 ORIGINAL DETAIL COUNT=				9200 5712 3488 0 3488	0 3488				
					TOTAL FINANCIAL PAYERS=	1				

DENIED CLAIMS

RECIPIENT	JOE	CO=01	RCC=	CLAIM NUMBER= 102006024600000NCXIX	EST AMT DUE=					
	987654321K	PAT ACCT=54321		MED REC=54321	ATTN PROV=79XXXXX	1.0000				
NCXIX	09012006 09012006	1.000		99212 OV ESTABLISHED PT, MINOR-PH KA	9200 5712 3488 0 3488	0 3488	0 0 24			
DED=	.00	PT LIB=	.00	CO PAY=	.00	TPL=	.00	DIFF=	.00	
ORIGINAL BILLED AMOUNT=	92.00 ORIGINAL DETAIL COUNT=				9200 5712 3488 0 3488	0 3488	0 0 24			
					TOTAL FINANCIAL PAYERS=	1				

ICN

EOB

What does that claim number mean?

102006023600000NCXIX

- Region = **10**
- Year = **2006**
- Julian date = **023** (January 23, 2006)
- Batch = **600**
- Number of claims in batch = **000**
- Payer code = **NCXIX**

Remittance and Status Report (RA)



- ❑ Providers must retain all RAs for at least 5 years
- ❑ Should be kept in chronological order
- ❑ Claim and payment summary
- ❑ Claim documentation

Electronic Commerce Services



- ❑ Electronic Funds Transfer
- ❑ EDI Support
- ❑ Support Electronic Transactions

HIPAA Transactions



- ❑ 837 Health Care Claim
- ❑ 835 Health Payment and Remittance Advice
- ❑ 270/271 Health Plan Eligibility
- ❑ 276/277 Health Care Claim Status
- ❑ 278 Referral Certification and Authorization

Billing Claims Electronically



- ❑ Vendor Software
- ❑ Clearinghouse
- ❑ In-house software
- ❑ NCECS-Web

NCECS Web-Tool



- ❑ Website that providers can use to submit their claims electronically to North Carolina Medicaid
- ❑ Allows providers to file adjustments electronically

FREE!!

<https://webclaims.ncmedicaid.com/ncecs>

Filing Adjustments Electronically



- Providers can file 2 types of adjustments electronically:
 - Void – claim will be recouped
 - Replacement – claim will be recouped and reprocessed

Contacting Medicaid



By Phone – 1-800-723-4337 Automated Voice Response System

By Phone – EDS' Automated Attendant Line

- Check claim status, checkwrite information, prior approval and recipient eligibility

By Phone – Division of Medical Assistance

By Internet or Mail – DMA & EDS Addresses

- Carolina ACCESS (CCNC) and commercial insurance (CPL) information available

In Person – Travel Representatives



AVRS – Automated Voice Response System



- ❑ Up to 15 inquiries per call
- ❑ Refer to July 2001 Special Medicaid Bulletin for detailed instructions regarding the AVRS
- ❑ Refer to Appendix A for cheat sheet information regarding the AVRS



Basic Med Appendix A

Contacting Medicaid



By Phone – Call 1-800-688-6696 or 919-851-8888
– Automated Voice Response System

By Phone – Press "1" – Electronic Commerce Services
– EDS' Automated Attendant Line

By Phone – Press "2" – Prior Approval
– Division of Medical Assistance

By Internet or Mail – Press "3" – Provider Services
– DMA & EDS Addresses

In Person – Press "0" - Operator
– Travel Representatives



Contacting Medicaid



By Phone – Fraud and Abuse
DMA Program Integrity – 919-647-8000

By Phone – EDS' Automated Attendant Line
• Provider Enrollment

By Phone – DMA Provider Services – 919-855-4050
– Division of Medical Assistance

By Internet or Mail – Recipient Eligibility – over 12 months
DMA & EDS Addresses
DMA Claims Analysis – 919-855-4045

In Person – Travel Representatives



Contacting Medicaid



- Where can I download common forms?

By Phone – Automated Voice Response System
<http://www.dhhs.state.nc.us/dma/forms.html>

By Phone – EDS Automated Attendant Line
Where can I download bulletins?

<http://www.dhhs.state.nc.us/dma/bulletin.html>

By Phone – Division of Medical Assistance
• Where do I send paper adjustments?

By Internet or Mail – DMA & EDS Addresses
[EDS, PO Box 30009, Raleigh, NC 27622](#)

In Person – Travel Representatives
Where do I send in EDS prior approval requests?

[EDS, PO Box 31188, Raleigh, NC 27622](#)



Contacting Medicaid



By Phone – There are travel representatives for:
Automated Voice Response System

Physician Provider Types

By Phone – EDS' Automated Attendant Line
Hospital Provider Types

By Phone – Community Care Providers
Division of Medical Assistance

NCECS Web Based Tool

By Internet or Mail – DMA & EDS Addresses

In Person – Travel Representatives
EDS 800-688-6696 option 3



Basic Med Appendix D

Any Questions?



Video Conference Disclaimer



- ***This video conference is being presented on November 6, 2006 by Chris Ferrell, an employee of EDS, the Fiscal Agent for the North Carolina Medicaid Program. All information provided during this video conference is believed to be accurate and reliable; however, the Division of Medical Assistance (DMA) assumes no responsibility for the use of this information. In the event of discrepancies between the oral presentation, and the published information (general and special Medicaid bulletins), the published information shall be the final authority. Information presented during this video conference is also provided in the Basic Medicaid Billing Guide October 2006. This video conference is based on these written guidelines. The information presented in this video conference is subject to change. Providers are typically notified of changes and updates through subsequent general and/or special bulletins.***